International experiences on health care financing - toward universal coverage

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ASSA Seminar

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Structure of the presentation

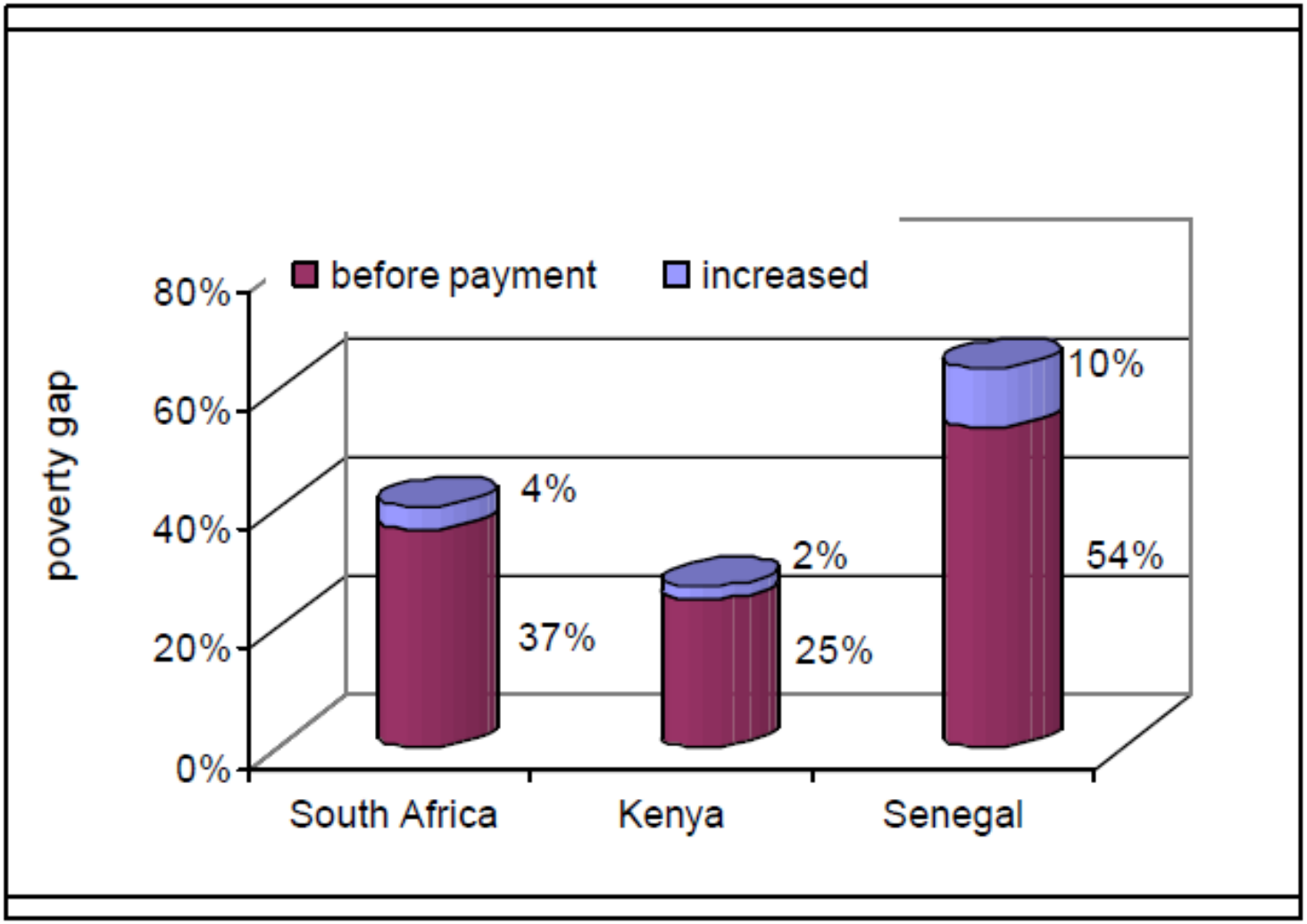
1. Poverty and health
2. Health care system
3. Health care financing
4. Development of health insurance
5. Concluding remarks

1. Poverty and health

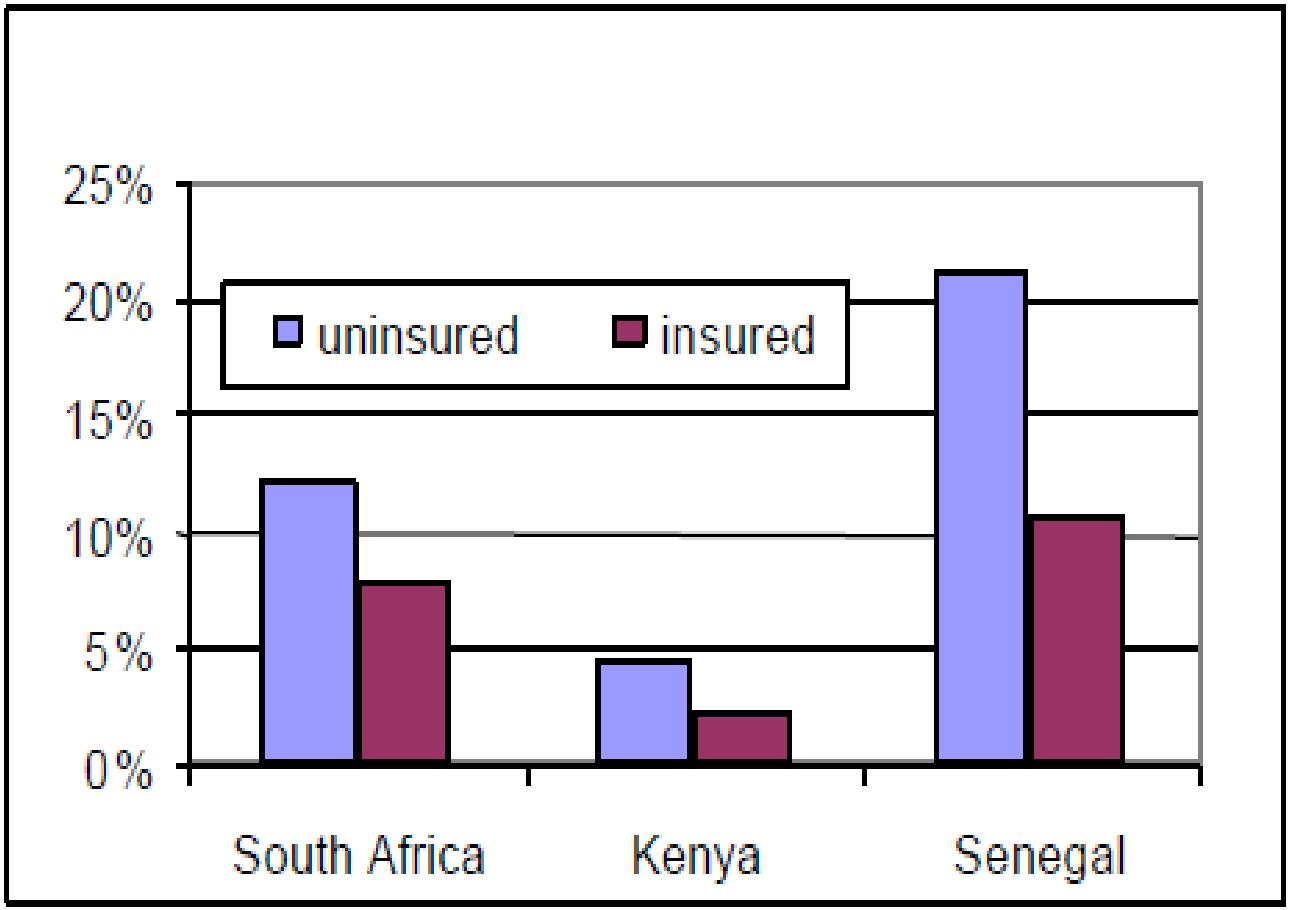
- **20% of the world population lives in abject poverty.**
- **80% of the world population does not have access to adequate social protection, most of them live in social insecurity.**
- **Every year 100 million people globally are forced into poverty by health care costs.**
- **Worldwide, 178 million people are exposed to catastrophic health costs.**

=> Notorious vicious circle of poverty and health

Impact of health payments on poverty gap



Percentage of households facing catastrophic expenditure



2. Health care system

Health care system should cater for better health outcomes (better health, e.g. life expectancy, lower fertilities, quality of life) which have a significant impact to people's income and poverty.

i.e. to provide quality care:

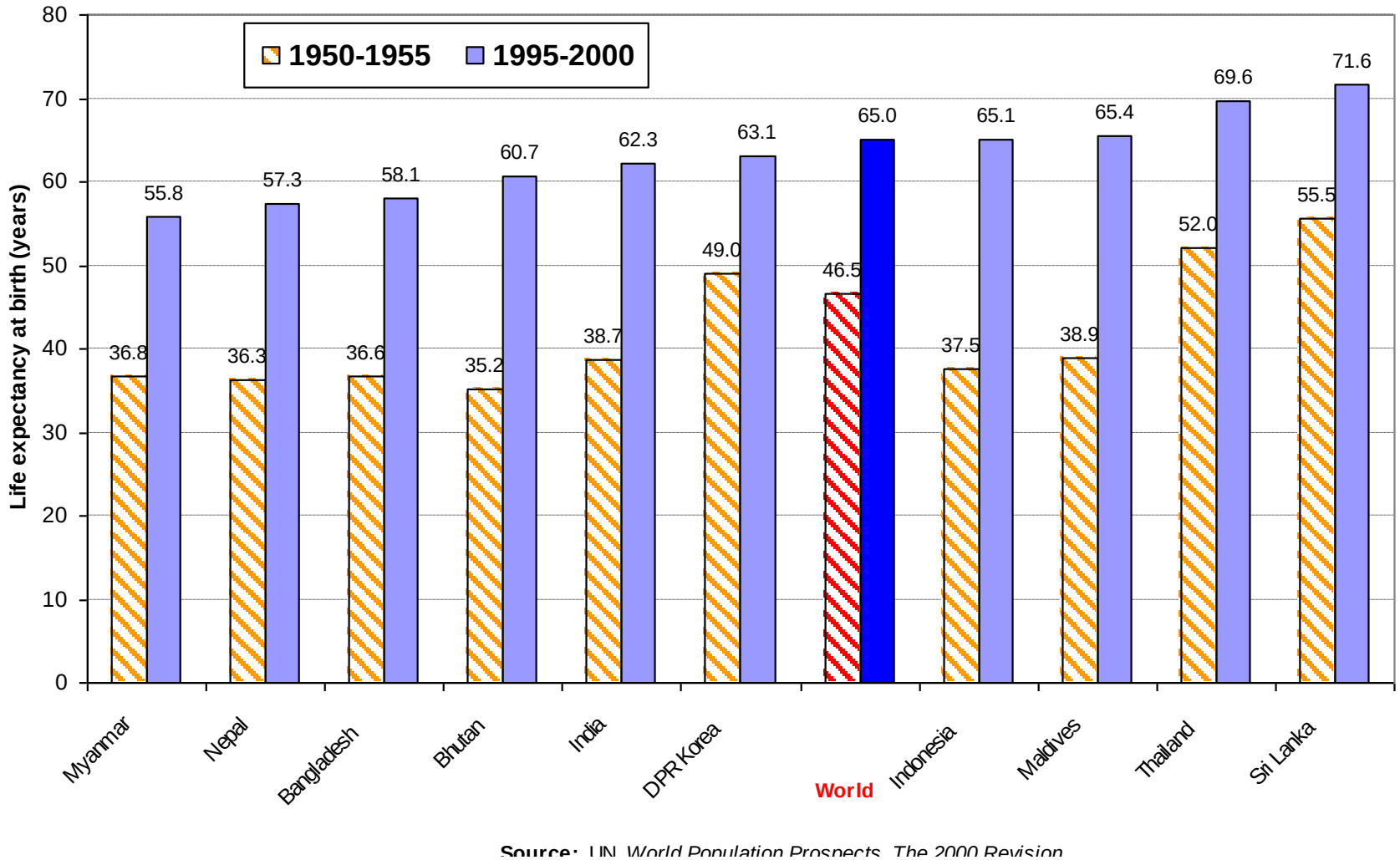
(1) to all (universalism) with adequate accesses

(2) with minimum total cost and

(3) with individual payments (e.g. contributions, taxations, copayment) to be related to capacity to pay (not the cost itself)

- **Equality**
- **Efficiency**
- **Equity**

Life expectancy in selected Asian countries, 1950-2000



Source: UN, *World Population Prospects, The 2000 Revision*

Elements of health care system

Physical elements

- Infrastructure (facilities and equipments)
- Materials / consumables, including drugs as a major element

Human resources

- Doctors
- Nurses
- Pharmacists etc.

Management / governance

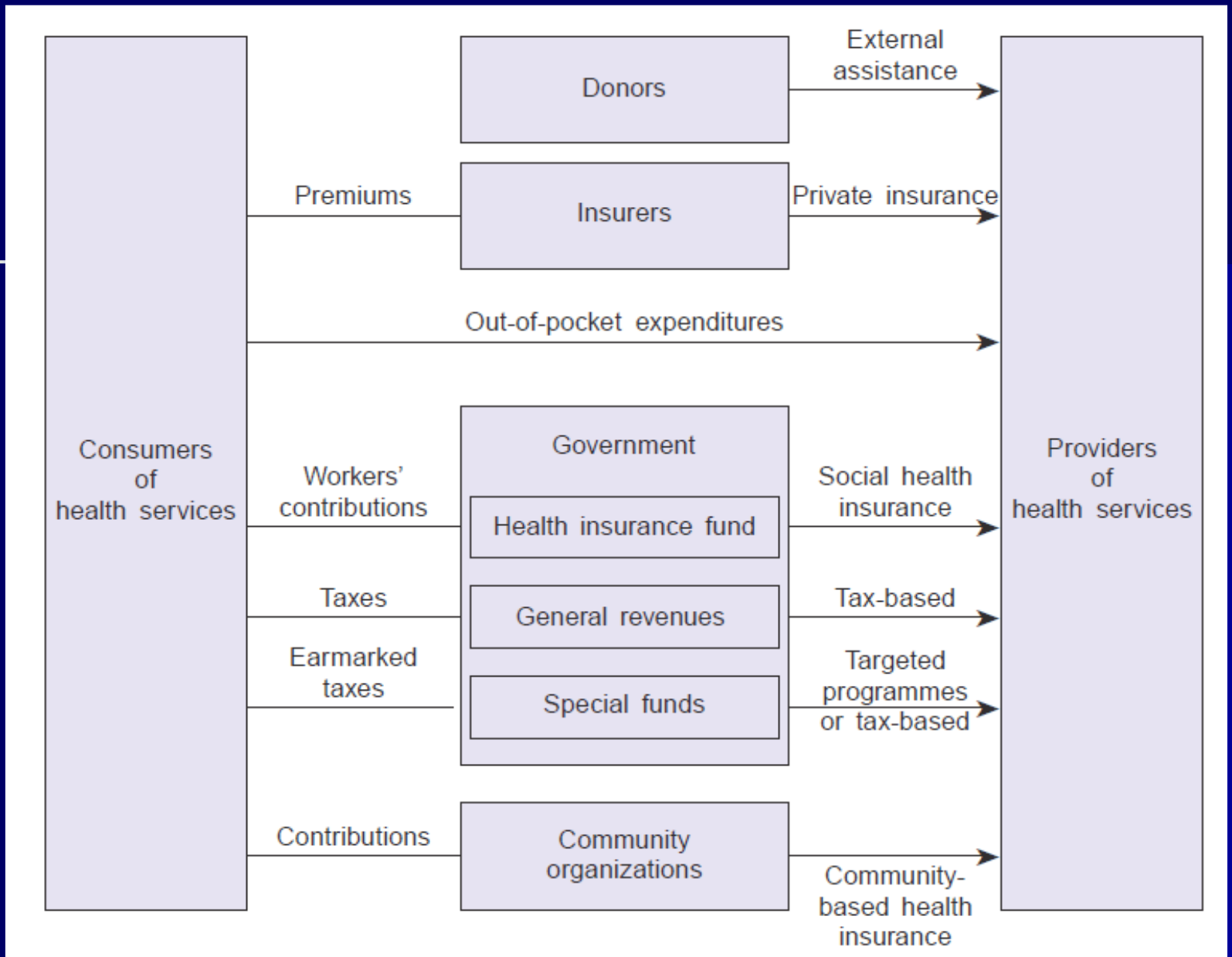
- Financing
- Legal systems
- Administration
- Education of health care personnel / population at large

=> Health care financing as one of the decisive factors / major challenges for the development of health care systems

3. Health care financing

1. Who pays to medical providers?
   Public / private / donor financing

2. How is the payment paid to medical providers?
   - Prepayment (risk pooling) / post payment (non risk pooling)
   - Fee-for-service / case payment / capitation etc.


Consumers of health services
Donors
External assistance
Premiums
Insurers
Private insurance
Out-of-pocket expenditures
Government
Workers' contributions
Health insurance fund
Social health insurance
Taxes
General revenues
Tax-based
Earmarked taxes
Special funds
Targeted programmes or tax-based
Contributions
Community organizations
Community-based health insurance
Providers of health services

1. **Prepayment system**

   Desirable in order to avoid catastrophic expenditure due to post payment

   => Tax or insurance system (risk-pooling)

   => lower out-of-pocket payment desirable

2. **‘Public’ financing system**

   Desirable in order to have significant redistribution (from rich to poor, from the healthier to the less healthy)

   => in principle, compulsory mechanism

   => tax / contribution related to income desirable (dependent coverage also desirable)

Formal social health protection coverage in % of population in selected Latin American countries and selected years between 1995 and 2004

Country	Public scheme	Social insurance	Private insurance	Other	Total (%)
Argentina	37.4	57.6	4.6	1.4	100
Bolivia	30.0	25.8	10.5	0.0	66.3
Colombia	46.7	53.3			100
Ecuador	28.0	18.0	20.0	7.0	73
El Salvador	40.0	15.8	1.5		57.3
Haiti	21.0		38.0		60.0
Honduras	52.0	11.7	1.5		65.2
Nicaragua	60.0	7.9		0.5	68.4

Formal coverage in social health insurance protection in selected countries of Africa and Asia

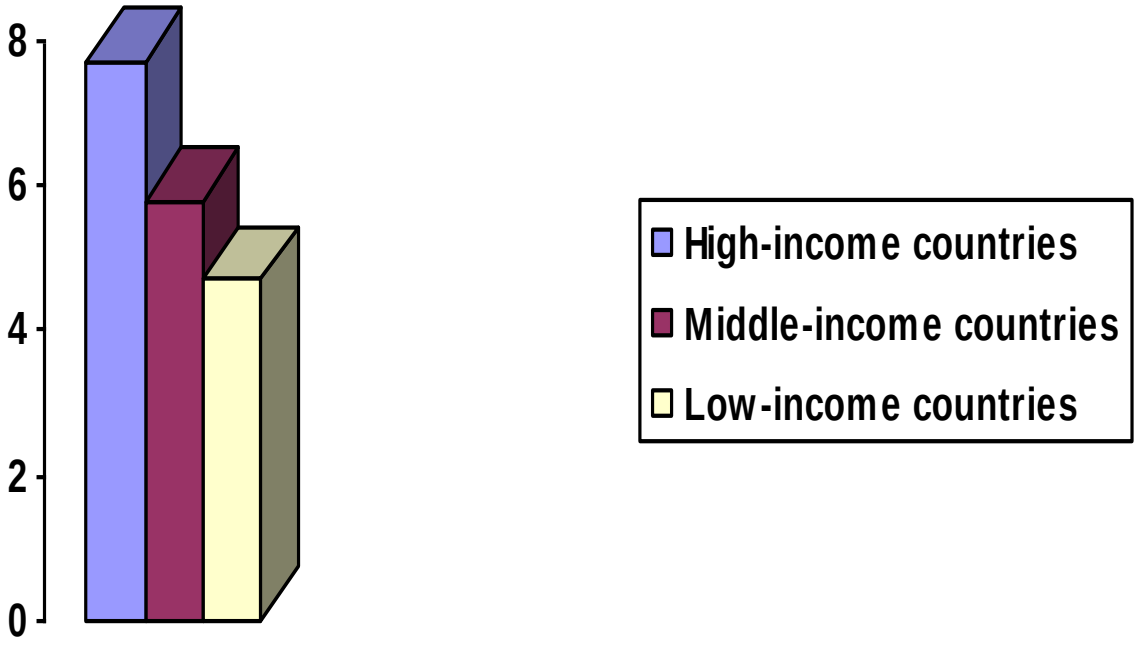
Country	Insurance schemes	Estimated formal coverage (in % of total population)
China	– Urban workers – Basic insurance – RCMS (new)	**10**
India	– EISIS – CGHS – CBHI	**20**
Indonesia	– ASKES – JAMSOSTEK – CBHI	**20**
Kenya	– NHIF	**7**
Lao People's Democratic Republic	– CCS – SSO – CBHI	**5**
Mongolia	– National scheme	**78**
Philippines	– Phil Health – CBHI	**55**
Senegal	– IMPs – MOH	**11.4**

Country/ Scheme	First Law/ Decree	Year started	Current Estimated Coverage	Comments
Australia Medicare (C) *	1972	1975	Universal	All citizens and legal residents are eligible. Family as the unit of coverage
China Urban workers Basic Insurance (C) RCMS (new) (V) *	1998 2003	2000 2003	10% of total population	Guidelines, not yet law. Implementation in stages by region. Limited to urban workers only, mainly in the public sector. Individual coverage in rural and urban schemes.
India ESIS (C) CGHS (O) CBHI schemes (V)	1948 1954 from 1950s		20% of total population (all schemes)	Family members covered but scheme excludes higher-salaried workers, and small enterprises. Very different arrangements by location, occupation and benefits.
Indonesia ASKES Jamsostek (C) CBHI (V)	1968 1991	1968 1992 1980	20% of total population	Families covered. Small enterprises excluded. Dependants limited to two children. Very different schemes
Japan Workers Community Elderly	1922 1938 1999	1927 1957 2000	Universal (from 1961)	Extension in stages by population group. Family coverage
Republic of Korea National scheme merging the existing schemes (compulsory)	1976	1977	Universal	Gradual extensions to different occupational sectors, family coverage.
Lao PDR CCS (C) SSO (C) CBHI (V)	1989 2000 2002	1989 2001 2002	5% of total population	All have family coverage. Reimbursement very limited by fund capacity. Still limited to capital city. Controlled extension of pilot projects.

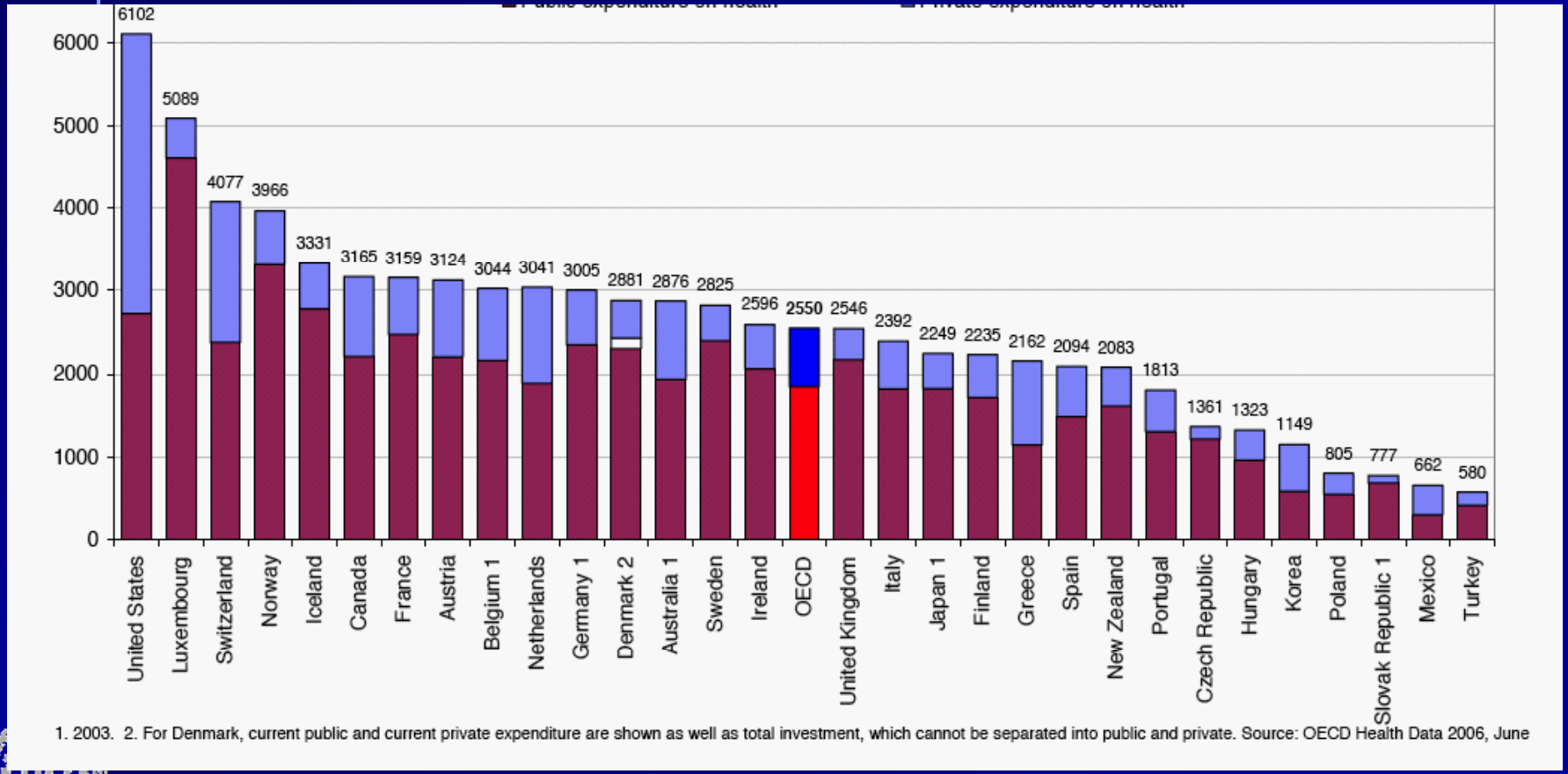
Country/ Scheme	First Law/ Decree	Year started	Current Estimated Coverage	Comments
Mongolia National scheme (C) (G)	1993	1994	78%	Initial universal coverage dropped, new systems will register self-employed.
The Philippines PhilHealth (C) (G) CBHI (V)	1994	1995	55% of total population	PhilHealth National Health Insurance Programme combines previous systems.
Singapore Medisave (C) Medishield (O) Medifund (G)	 1983 1989 1992	 1984 1990 1993	Universal	Three layers enable universal coverage for hospital-based benefits, with low cost public primary health care.
Thailand SSO (compulsory) CSMBS (civil servants) "Universal Coverage"	 1990 1978 2001	 1991 1978 2001	 (13%) (11%) (76%) Total 100%	 Dependants not covered. Dependants covered in non-contributory scheme. Rest of the population, completing universal access.
Viet Nam VSS (C) VSS (V) VSS-CBHI (V) HCFP (scheme for the poor (G)	 1992 1993 2002 2002	 1992 1994 2003 2003		 Dependants not covered. Students Informal sector. Acceleration of government programme to subsidize health insurance for the low-income populations, including family members except children under six years (still government-funded)

* (C) Compulsory, (V) Voluntary, (G) Government-funded programme, (O) Individuals can opt out.

Total health expenditure as a percentage of GDP

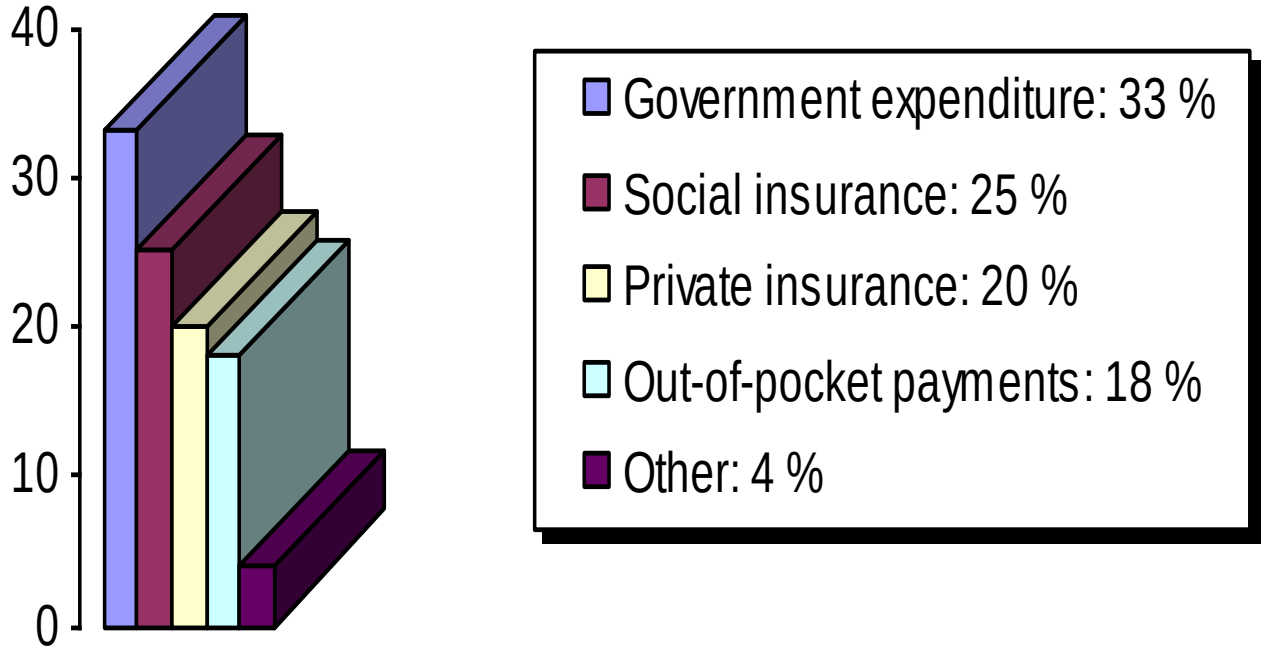


Public / private health expenditure per capita (OECD countries)



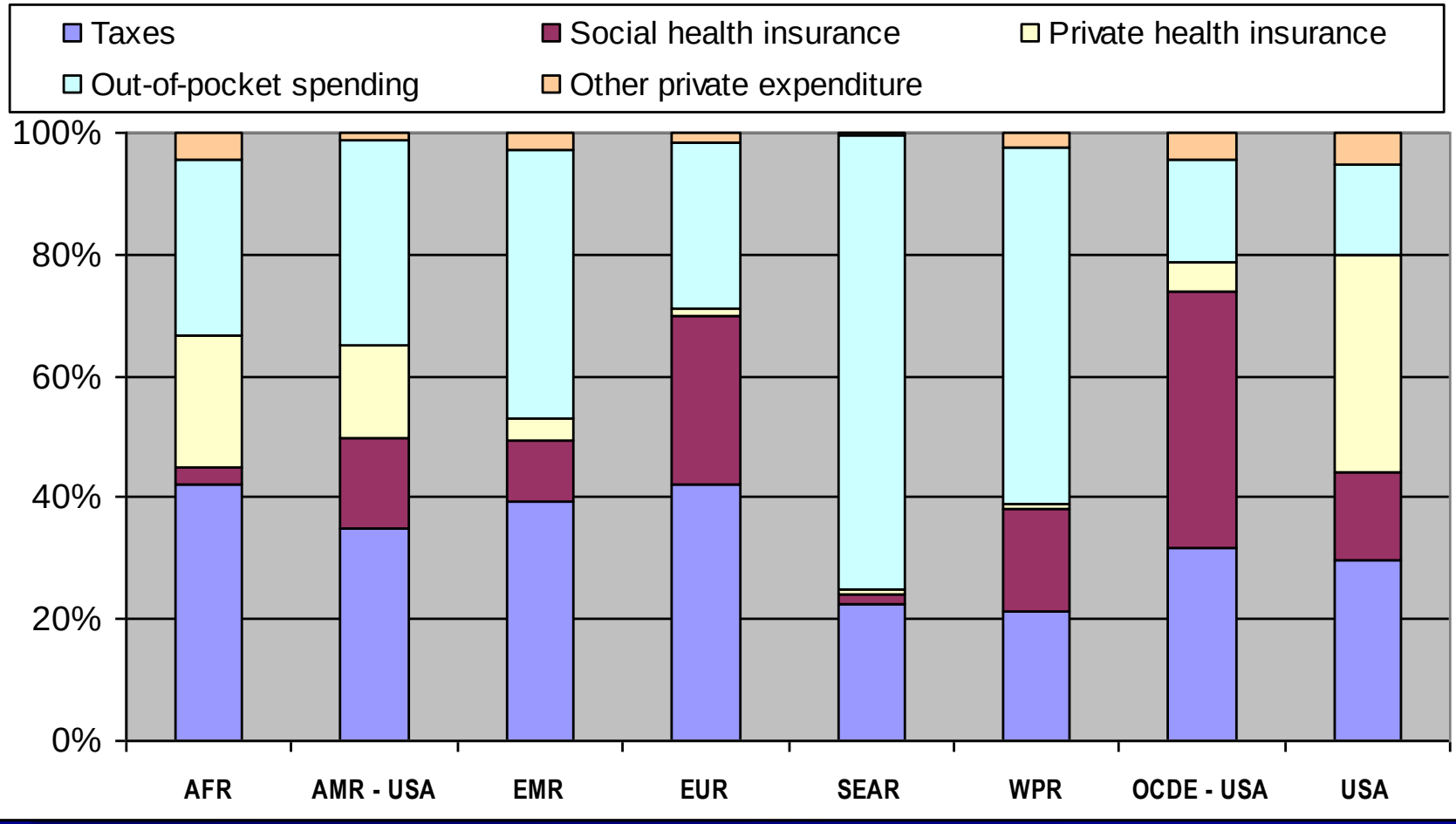
1. 2003. 2. For Denmark, current public and current private expenditure are shown as well as total investment, which cannot be separated into public and private. Source: OECD Health Data 2006, June

Financing of global expenditure on health



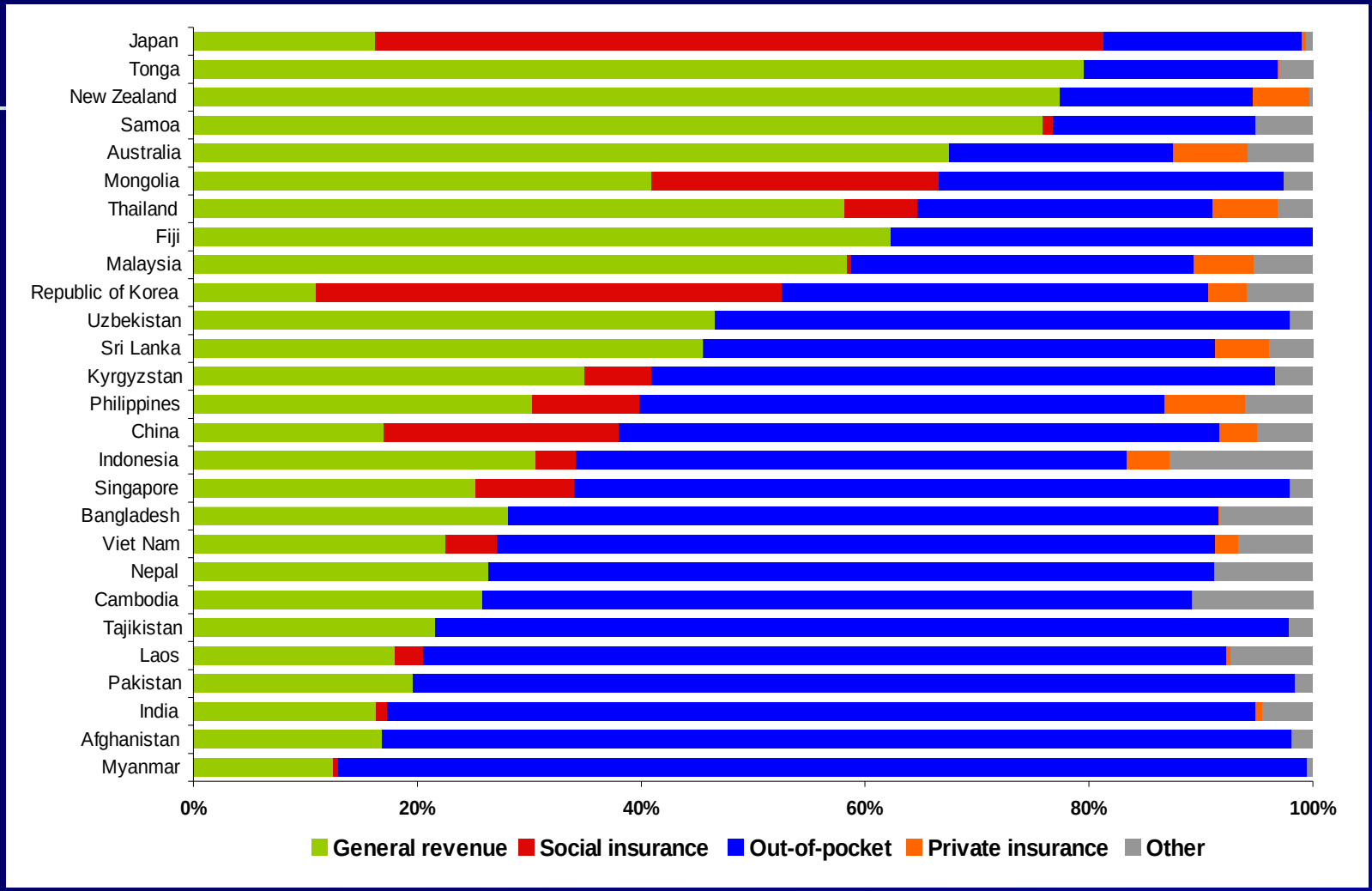
Composition of health spending - 2001

Data estimated unsing average annual exchange rate - Timor Leste not included



AFR: Africa, AMR: Americas, EMR: East Mediterranean, EUR: Europe,
SEAR: South East Asia, WPR: Western Pacific
Source: NHA Unit, EIP/FER/RER, World Health Organization

Sources of healthcare financing in selected Asia-Pacific countries (2004)



WHO World Health Statistics 2007

Public expenditure on health as a percentage of total health expenditure

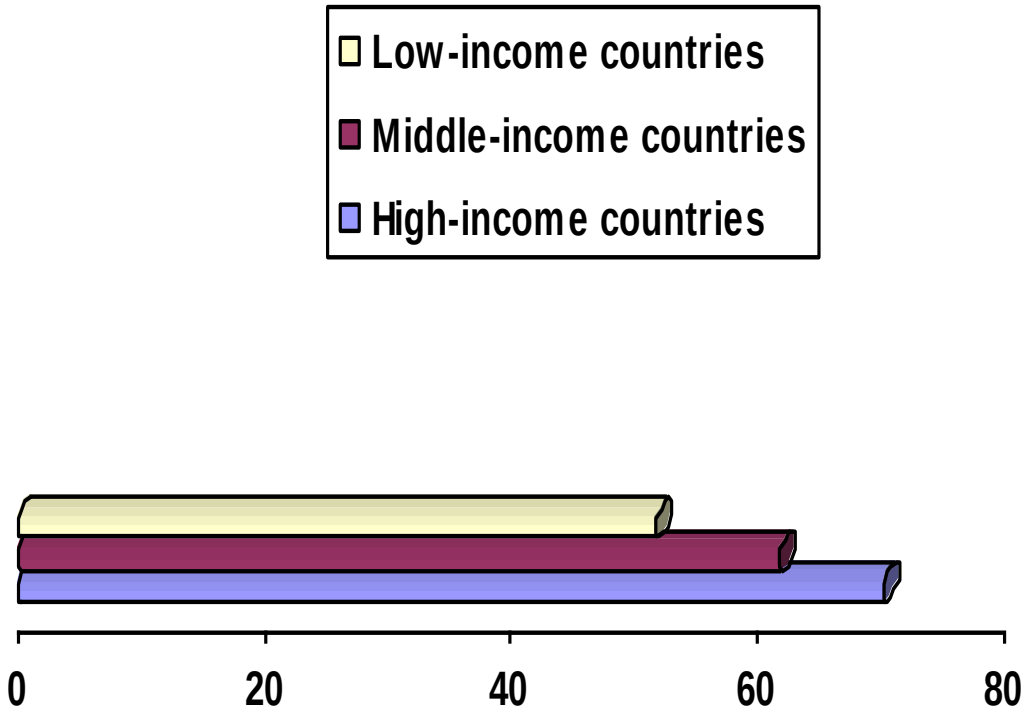
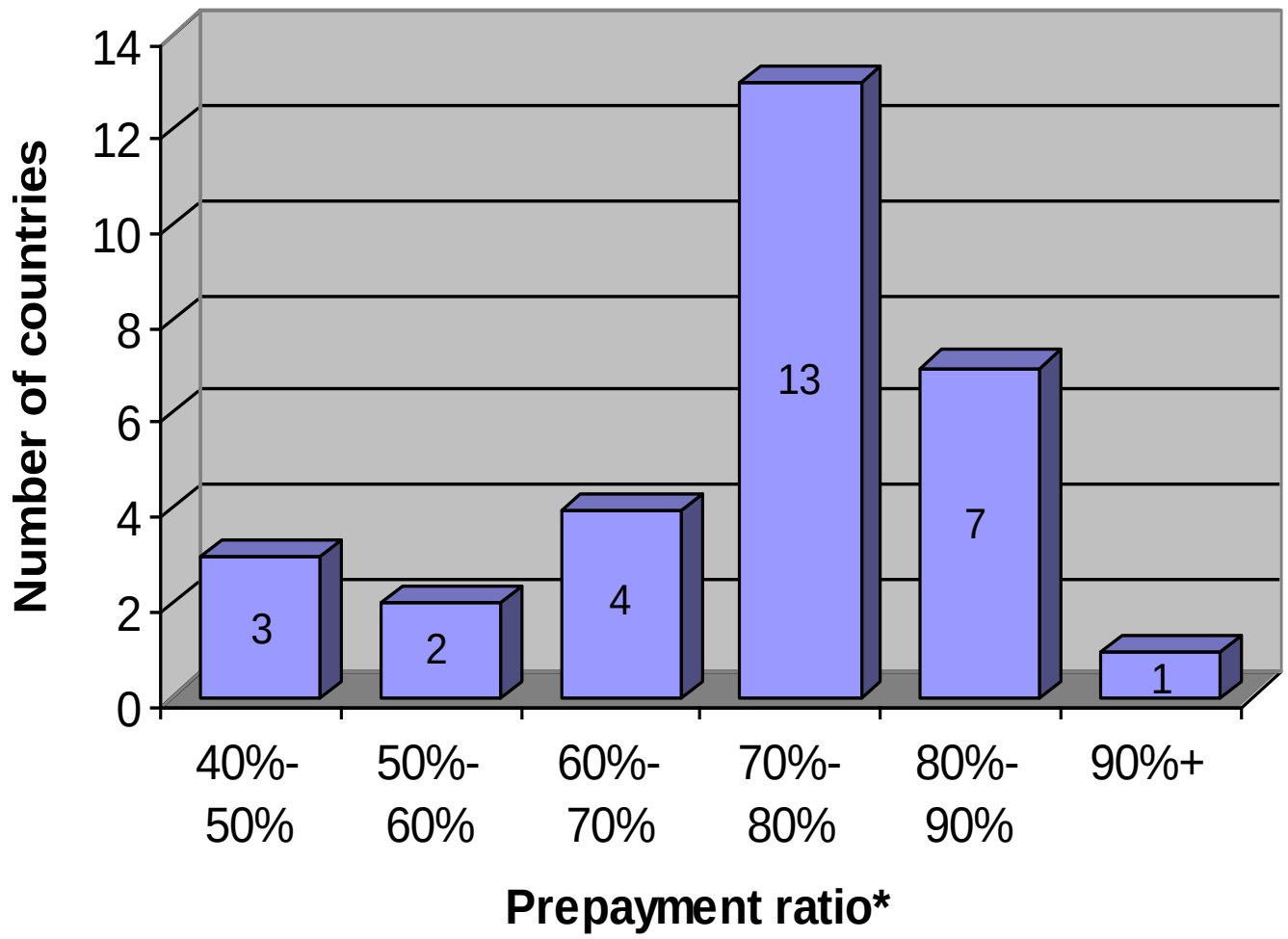


Table 3.1. Share of total expenditures on health by type and region, 2003

	Public expenditure (percentage of total)	*Private expenditure (percentage of total)*	
		Out-of-pocket	*Others*
South Asia	26.3	68.3	2.7
East Asia and Pacific	39.0	53.2	7.0
East Europe and Central Asia	67.3	25.7	6.5
Latin America and Caribbean	48.2	38.6	12.6
Sub-Saharan Africa	41.2	25.3	28.0
North Africa and Middle East	50.9	43.1	5.2

Source: World Bank, *World Development Indicators, 2006* (Washington, D.C., World Bank, 2006) table 2.14.

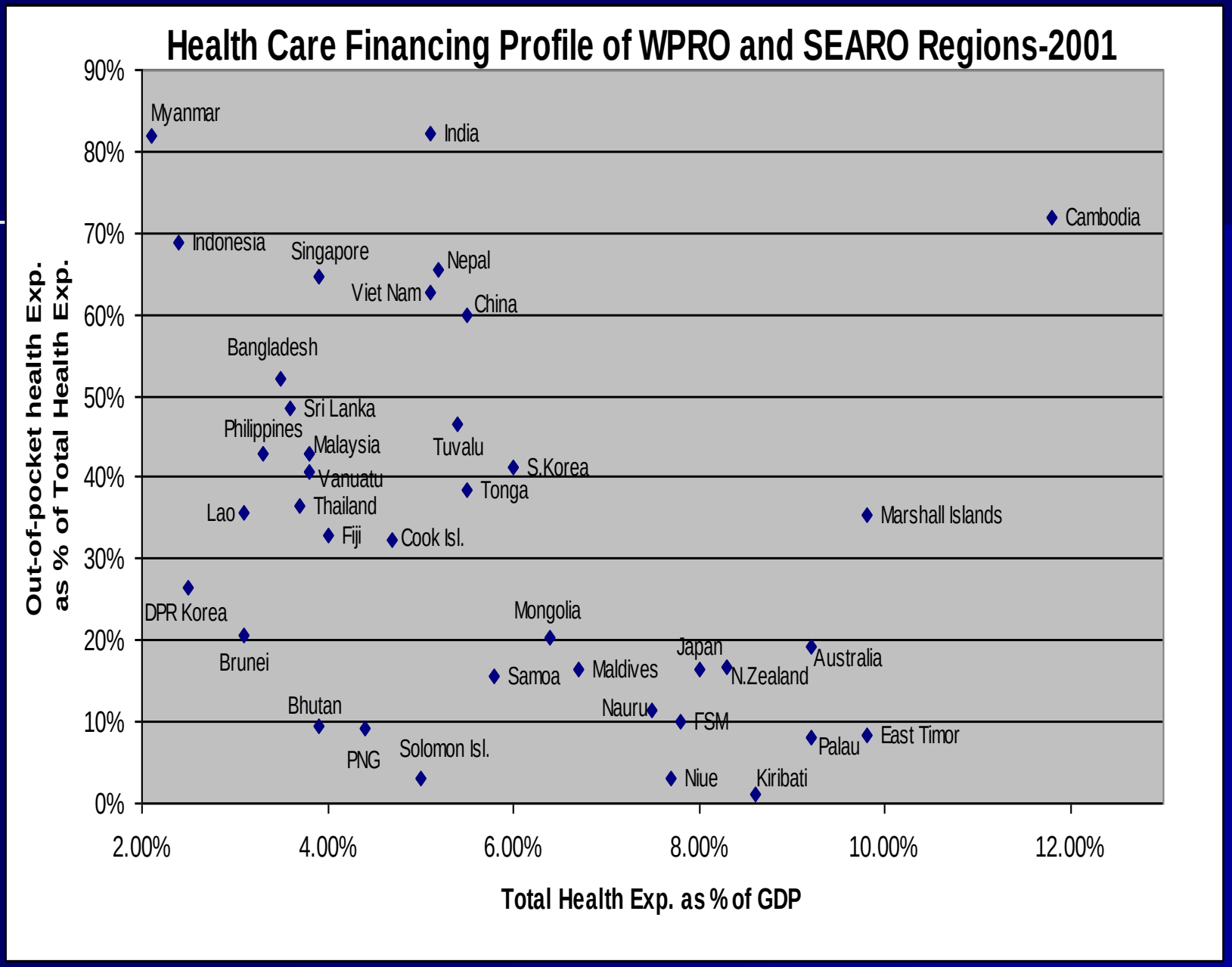
Prepayment in the OECD countries



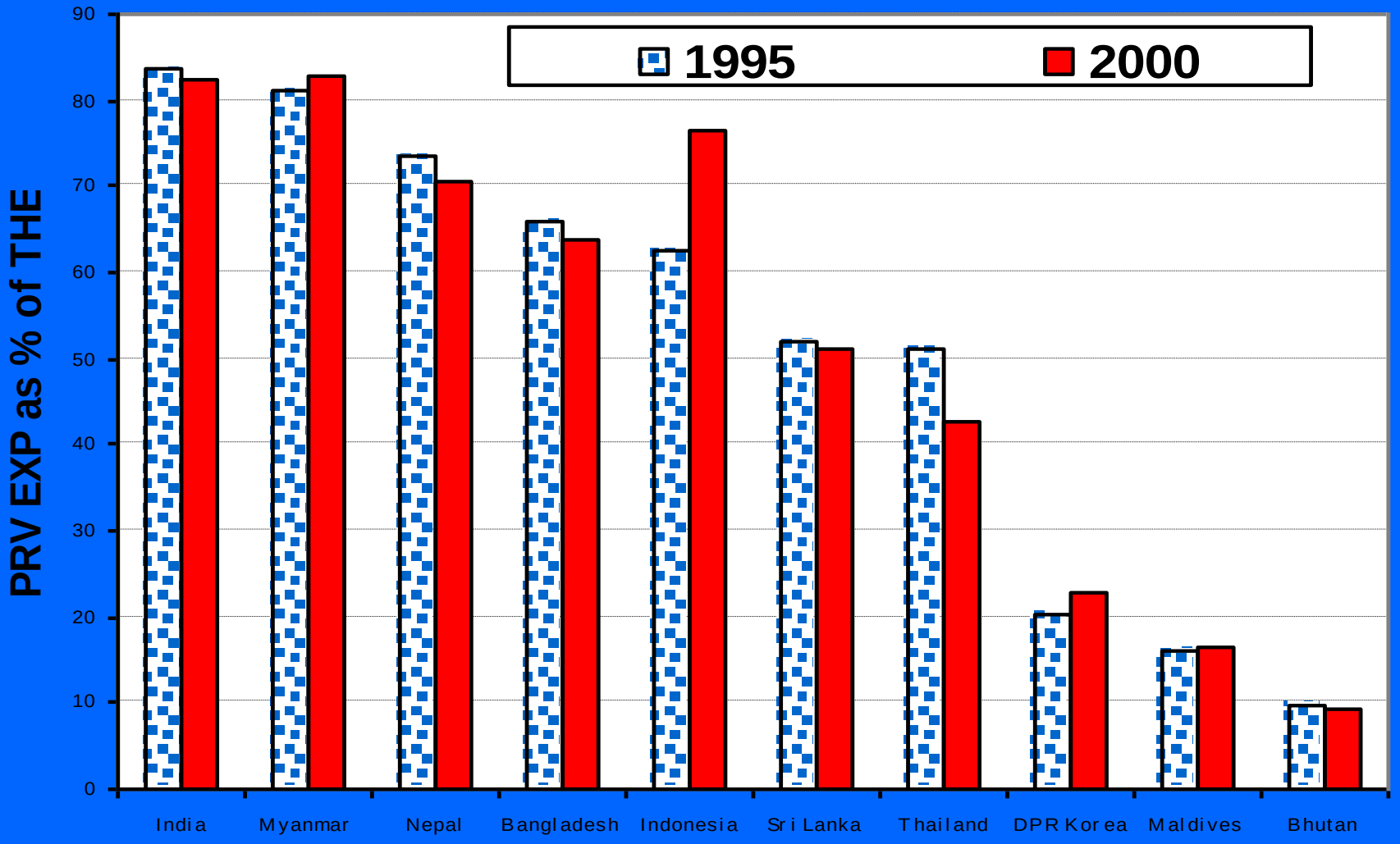
*Health expenditure financed via UC health financing system/total health expenditure

Prepayment ratios in selected mature SHI systems, 2001

Country	Prepayment Ratio (%)	Country	Prepayment Ratio (%)
Austria	69.3	Israel	69.2
Belgium	71.7	Japan	77.9
Costa Rica	68.5	Luxembourg	89.9
France	76.0	Netherlands	63.3
Germany	74.9	ROK	44.4
		Switzerland	57.1


Health Care Financing Profile of WPRO and SEARO Regions-2001
Out-of-pocket health Exp. as % of Total Health Exp.
Total Health Exp. as % of GDP
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2.00%
4.00%
6.00%
8.00%
10.00%
12.00%
Myanmar
India
Cambodia
Indonesia
Singapore
Nepal
Viet Nam
China
Bangladesh
Sri Lanka
Philippines
Malaysia
Tuvalu
S.Korea
Vanuatu
Tonga
Lao
Thailand
Marshall Islands
Fiji
Cook Isl.
DPR Korea
Mongolia
Brunei
Japan
Australia
Samoa
Maldives
N.Zealand
Bhutan
Nauru
FSM
Palau
East Timor
PNG
Solomon Isl.
Niue
Kiribati

Private Expenditure on Health as % of Total Health Expenditure (THE), 1995-2000, SEAR Countries



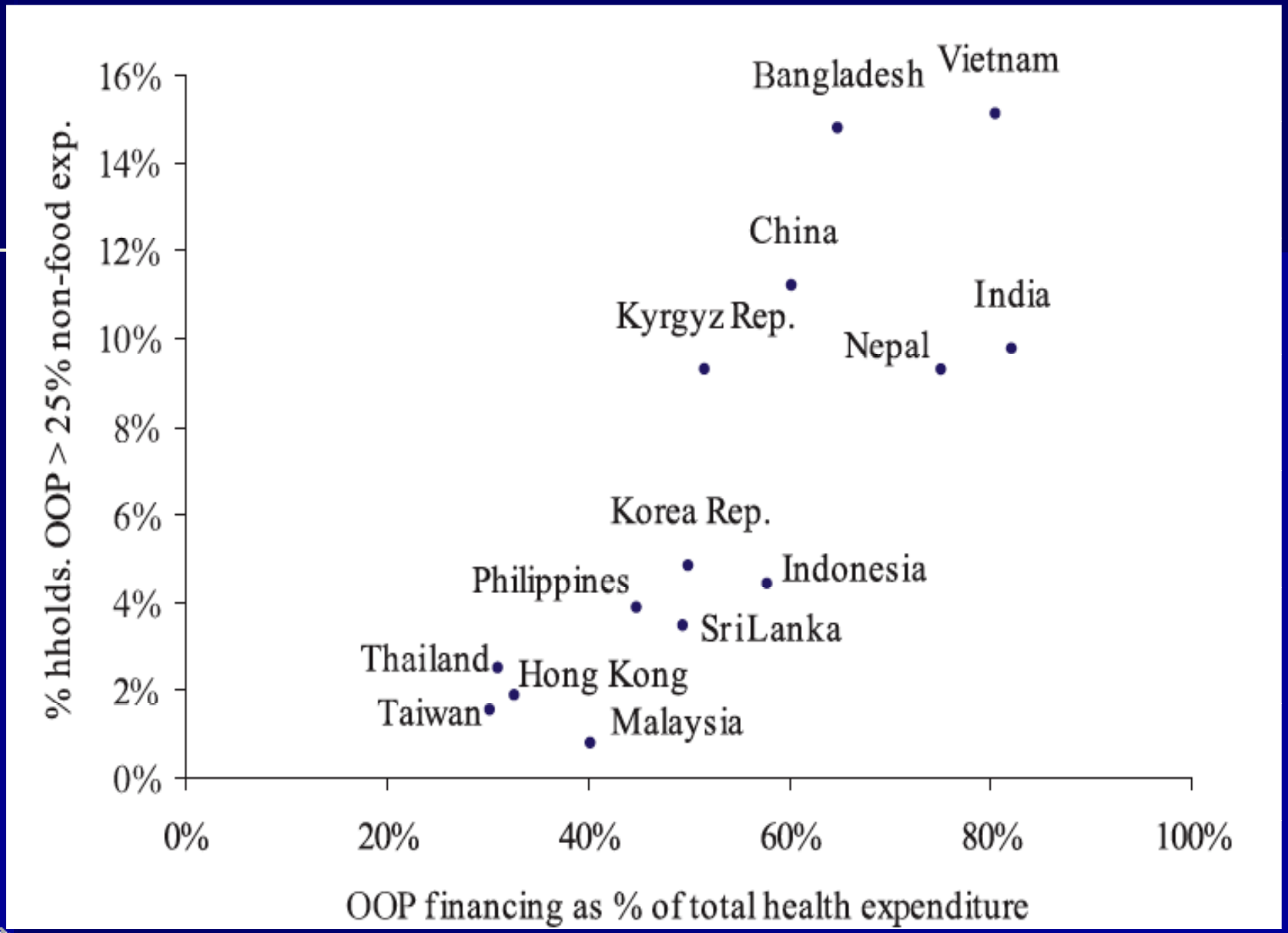
Source: WHR 2002

Increasing share of private financing

	Total HE, %	Government, %	Private HE,%
Samoa	100.0	76.2	23.8
Fiji	100.0	65.2	34.8
Cook Islands	100.0	62.8	37.2
Malaysia	100.0	58.8	41.2
Tonga	100.0	46.8	53.2
Philippines	100.0	45.7	54.3
Lao PDR	100.0	38.0	62.0
China	100.0	36.6	63.4
Viet Nam	100.0	25.8	74.2
Cambodia	100.0	24.5	75.5

Minimal financial protection, limited risk sharing and fund pooling practices

Source: NHA report. WHR-2004



Source: van Doorslaer et al. (2007)

Health expenditure in selected Asia and Pacific countries

Country	Health spending that is public (%)	Health spending that is private (%)	Health spending as % of GDP	Per capita spending (USD)
Afghanistan			8.0 %	14
Bangladesh (2001)	25%	75%	3.4%	12
Cambodia (2004)	35%	65%	6.4%	23
China (2002)	36%	64%	5.5%	54
India (2002)	21%	79%	6.1%	29
Indonesia (2002)	36%	64%	3.2%	30
Malaysia (2002)	55%	45%	3.7%	143
Nepal (2002)	27%	73%	5.2%	12
Pakistan (2002)	35%	65%	3.2%	16
Philippines (2002)	42%	58%	3.0%	29
Sri Lanka (2002)	45%	55%	3.6%	31
Thailand (2001)	56%	44%	3.1%	63
Vietnam (2002)	29%	71%	5.2%	23

1.1 **Source: Dr. Ravi P. Rannan-Eliya, Extending Social Health Protection in Asia-Pacific Region: Progress and Challenges (forthcoming)**

Taxation as percentage of GDP

Countries	Total Tax Revenue	Taxes on International Trade	Excises	General Sales Taxes	Social Security
Low-income (31) <$760 per capita	14.0	4.5	1.6	2.7	1.1
Lower middle (36) $760-3030 pc	19.4	4.2	2.3	4.8	4.0
Upper middle (27) $3030-9600 pc	22.3	3.7	2.0	5.7	5.6
High-income (23) >9600 per capita	30.9	0.3	3.1	6.2	8.8

Source: WHO CMH Report 2001 p59

External Resources for Health as % of Public Health Expenditure (PHE), 1995-2000, SEAR and ASEAN countries

Source: WHR 2002

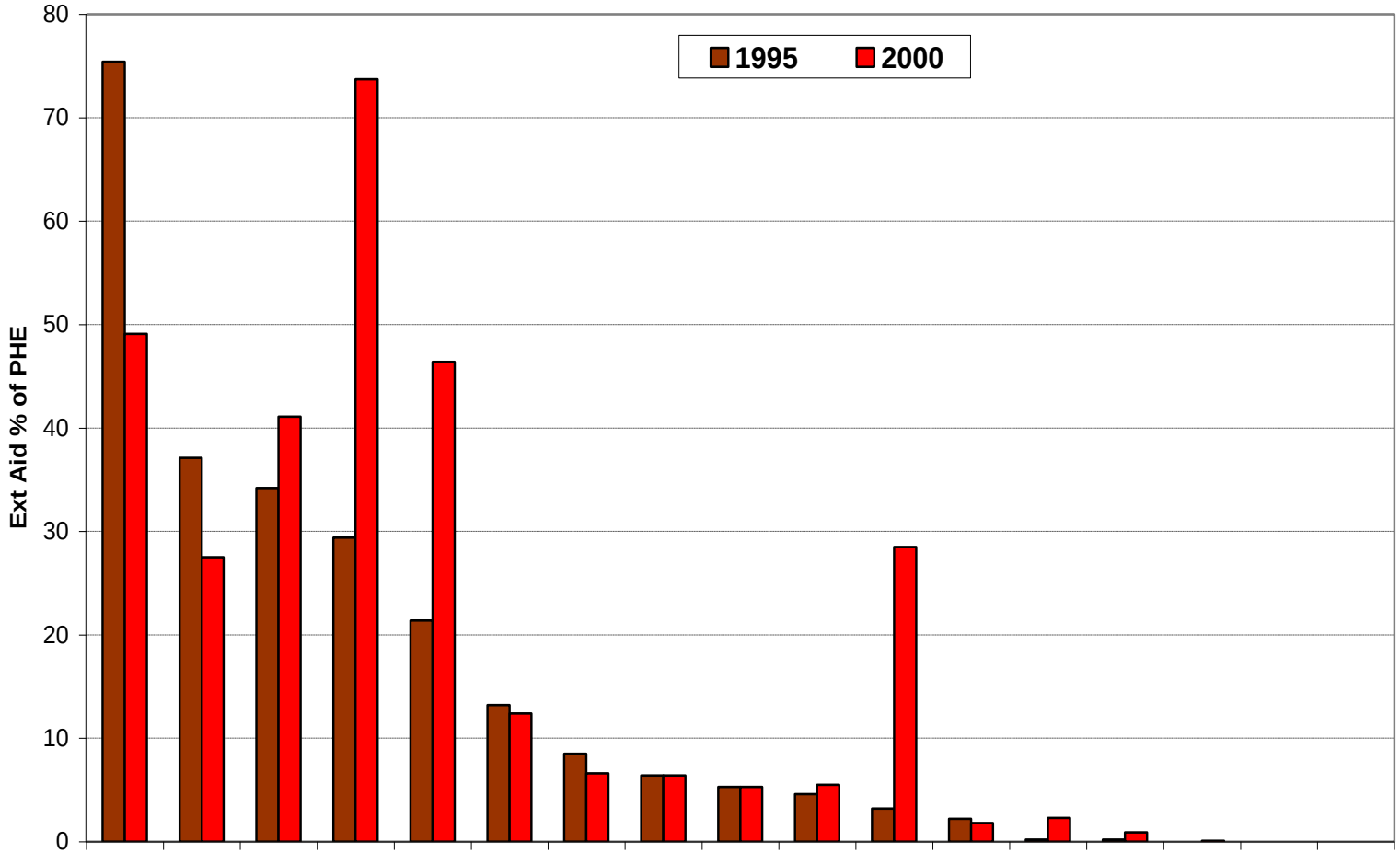


Table 2: *Contribution levels in the Social Health Insurance Schemes (by Country/Scheme)*

Country/ Scheme	Employer % of salary	Employee/ (% of salary) HH% income or flat rate	Government	Total	Comments (on co-payment and benefit limits)
Australia					
Medicare	0%	1.5 -2.5% of income	Rest of budget	NA*	Co-payments: 15% of primary care fee, some others. Separate drug scheme.
China					
Urban workers	6.0%	2.0%	0.5% in some cities	8%	Co-payments: 20% for most services. Partially in individual account.
RCMS (new)	NA	Flat rate, less than 1% of income	May reach matching amount	NA	High co-payments and ceilings.
India					
ESIS	4.75%	1.75%	As employer	6.5%	No co-payments, care in scheme facilities. Most have ceilings for reimbursement.
CGHS		Flat rate			
CBHI schemes		Wide range			

Country/ Scheme	Employer % of salary	Employee/ (% of salary) HH% income or flat rate	Government	Total	Comments (on co-payment and benefit limits)
Indonesia					
ASKES	0.5%	2.0%	As employer	NA	No co-payment.
Jamsostek	3-6%	0%	Some subsidy		Ceilings on reimbursement.
CBHI		Wide range			
Japan					
Workers	4.0%	4.0%	Mgnt 50%	NA	30% co-payment.
Community	-	Varies by income	paid by local govt. 33% of expenditure		30% co-payment.
Elderly	Transfers	Transfers			66% transfer .
Welfare	-	--	All costs		10% co-payment.
Republic of Korea					
NHIP salaried	1.95%	1.95%	20-45% of contribution for self-employed		High co-payments, according to service, reaching average of over 50%.
Self-employed	-	According to assets			
Medical-Aid (3%)	-	-	Pays in full		Same benefits as other sectors
Lao PDR					
CCS	--	6% for all social security	As employer	NA	No co-payment but amount limited.
SSO	2.2%	1.8% Flat rate, About 2% income	--		No co-payments.
CBHI	--		--		No co-payments.
Mongolia					
Salaried	3.0%	3.0%	-	NA	5-15% co-payments for hospital care.
Self-employed	-	Flat rate	Government pays flat rate		50-90% co-payment for drugs.
Indigent/ vulnerable					
Philippines					
PhilHealth	1.25%	1.25%	Central and local level pay for indigent families	NA	Ceilings for most care create low "support value".
CBHI	-	Flat rate			Some have ceilings
Indigent	-	Flat rate-2%			Low support.
Singapore					
Medisave/ Medishield	3.0-4.0%	3.0-4.0%	Funds all	NA	Percentage linked to age group.
Salaried	-	5% net income			20% Co-payment.
Self-employed	-	-			
Medifund					

Country/ Scheme	Employer % of salary	Employee/ (% of salary) HH% income or flat rate	Government	Total	Comments (on co-payment and benefit limits)
Thailand SSO (Covers health care, maternity, disability, death and cash allowances	1.5%	1.5%	1.5%	4.5%	No co-payments Government benefit scheme for civil servants Government-all others through UC system.
Viet Nam VSS VSS -Students VSS-CBHI HCFP (Scheme for the Poor	2.0%	1.0% Flat rate about $4-5/ person	As employer Fully supports "Meritorious Persons" Subsidies and Full support		20% co-payment (pensioners/ meritorious exempted) No co-payment.

*NA – not available

Table 3: *Provider payment methods in Social Health Insurance Schemes by country*

Country/ Scheme	Main Payment method for Community Ambulatory Care	Main Payment Method for Hospital Care	Comments
Australia			
Medicare	Fee-for-service	Per in-patient day in private hospitals	Fixed fee schedules. Most hospital benefits provided in public hospitals where staff are salaried, DRGs widely used.
China			
Urban workers	Fee-for-service	Various methods	Most pay fee-for-service, but some areas now use case payment, per inpatient day and capitation.
RCMS (new)	Fee-for-service	Fee-for-service	Few use capitation.
India			
ESIS	Salaried staff	Salaried staff	Most services in ESIS/CGHS facilities
CGHS	Salaried staff	Salaried staff	Fee-for-service for outside services
CBHI Schemes	Fee-for-service Capitation	Fee-for-service Capitation	Schemes facilities. Some have own health facilities.
Indonesia			
ASKES	Salaried staff	Salaried staff	*Askes* own health care facilities.
Jamsostek	Fee-for-service	Fee-for-service	Some schemes use capitation.
CBHI	Fee-for-service	Fee-for-service	

Country/ Scheme	Main Payment method for Community Ambulatory Care	Main Payment Method for Hospital Care	Comments
Japan Workers Community Elderly	Fee-for-service Fee-for-service Fee-for-service	Fee-for-service Fee-for-service Fee-for-service	Case payment in university hospitals, Some now use adapted DRGs. Government budgets for specific services (e.g. for new and emerging infections).
Republic of Korea All population	Fee-for-service	Fee-for-service	Fee-for-service remains the only method Fixed-fee schedules
Lao PDR CCS SSO CBHI	Salaried staff Capitation Capitation	Fee-for-service Capitation Capitation	Based on hospital user charges Capitation paid to hospital as main provider. Capitation paid to hospital as main provider. Fee-for-service payment by SSO for services outside capitation agreement.
Mongolia All populations	Capitation	Case payment per admission	Capitation is paid to the family general practitioners.
Philippines PhilHealth All populations CBHI	Fee-for-service Fee-for-service Capitation	Fee-for-service Fee-for-service Capitation	Guidelines for fees in public hospitals, private hospitals can set own fees. Capitation now tried. Some schemes have own primary health care facilities.
Singapore All populations	Fee-for-service	Per inpatient day Case payment	Fixed-fee schedules, but private practitioners and hospitals charge more.

Country/ Scheme	Main Payment method for Community Ambulatory Care	Main Payment Method for Hospital Care	Comments
Thailand			
SSO	Capitation	Capitation	Capitation paid to hospital as main provider. Fee-for-service payment by SSO for services outside capitation agreement.
Viet Nam			
VSSI – compulsory and voluntary	Fee-for-service	Fee-for-service	Total amount to single provider is capped.
VSSI – Poor	Capitation	Capitation	Trials with capitation for community (voluntary) populations and health cards for poor started in 2003.

4. Development of health care financing

Table 2-1 Models of social security/welfare states

Models	Characteristics	Countries and regions	Basic principles
A. Universal-model	• Considerable benefits • Universal coverage • Maintained mainly by tax revenues	Scandinavian countries UK (but moving toward the model C)	"Public assistance" (Pub-licness)
B. Social insurance model	• Benefits according to payments • Mainly covers employees • Maintained mainly by premiums	Germany, France, etc.	Mutual assistance (Recip-rocal help/Cooperation within communities)
C. Market-oriented model	• Minimum public assistance • Private insurance systems play the leading role • Depend on self-help and volun-teer assistance	USA	"Self-assistance"

Table 2-4 Comparison of the insurers (financial funders) of health insurance systems and pension systems by country

	USA	UK	Germany	France	Japan
Health insurance	National government (Medicare) + Private insurance companies	National government (NHS) <funded by taxes>	900 private health insurance organizations in eight groups (Krankenkassen)	Several private health insurance organizations (Caisse d'assurance maladie)	About 5,000 insurers (National government/Health Insurance Associations: 1,800/Municipalities managing NHI programs: 3,200)
Pensions	National government + Private insurance companies	National government (National insurance)	Individual corporations	Individual corporations	National Pension Plan = National government Employees' Pension Plan = National government

Social insurance group

Table 2-5 Comparison of the basic structure of the health care system

	UK	Germany	France	Japan	USA
Health care services are provided by:	The public sector	The public sector	The public sector	The private sector	The private sector
	Almost 100%	About 90%	About 70%	About 20%	About 25%
Health care system is financed by:	The public sector	The public sector	The public sector	The public sector	The private sector
	Tax revenues	Premiums	Premiums	Premiums + Tax revenues	

Note: The lower column for "Health care services are provided by:" indicates the proportion of public hospitals of the total number of hospitals in each country. The figure for Germany includes hospitals run by public service corporations (such as religious corporations and foundations).

Table 2-6 Delivery and finance of the health care system (%)

	Delivery	Finance	
Europe	Public	Public	.....Public sector type
USA	Private	Private	.....Private sector type
Japan	Private	Public	.....Combination type

Historical development of formal health protection coverage

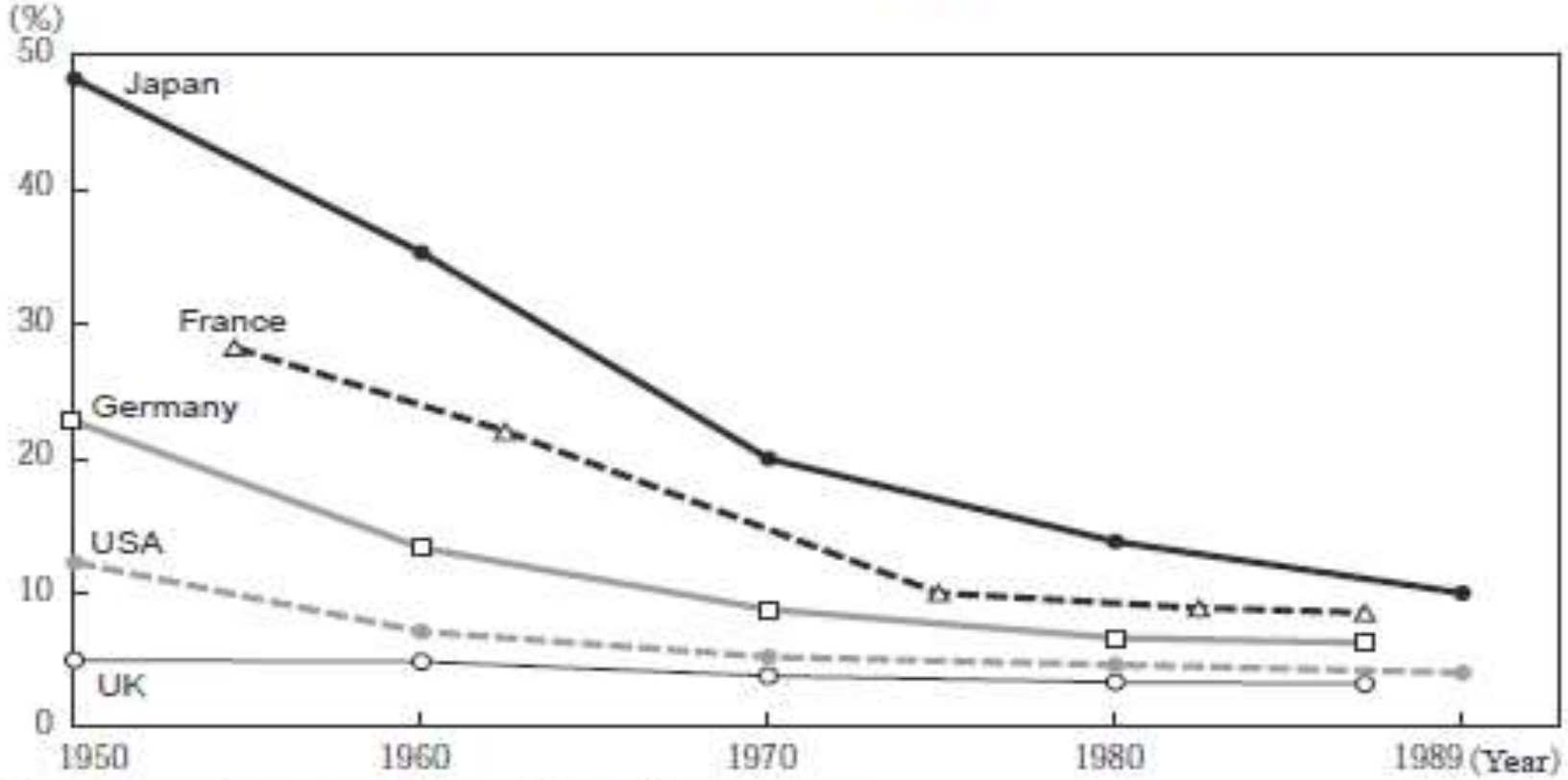
Country	Year	Total number of insured as a % of total population	GDP per capita / US$ exchange rate
Austria	1920	18.3	-
	1923	32.7	-
	1924	34	-
	1925	34.3	-
	1970	91	1 997
	1980	99	10 530
	2000	99	23167
Canada	1970	100	3 985
	1980	100	10 843
	2000	100	22 708
France / Alsace-Lorraine	1921	22.9	-
France	1920	31.7	-
	1925	32	-
	1970	95.7	2 884
	1980	99.3	12 742
	2000	99.8	21 884

Country	Year	Total number of insured as a % of total population	GDP per capita / US$ exchange rate
	1921	35.2	-
Germany	1922	35	-
	1925	35	-
	1970	88	3 044
	1980	91	13 145
	2000	-	22 814
Great Britain / United Kingdom	1927	3.3	-
	1970	100	2 205
	1980	100	9 524
	2000	100	23 954
Japan	1970	100	1 971
	1980	100	9 164
	2000	100	37 544

Country	Year	Total number of insured as a % of total population	GDP per capita / US$ exchange rate
Republic of Korea	1922	16,6	-
	1970	-	272
	1980	29.8	1 632
	2000	100	9 671
Luxembourg	1920	21.3	-
	1925	21.6	-
	1970	100	3 728
	1980	100	14 433
	2000	-	43 083
Norway	1970	100	3 285
	1980	100	15 519
	2000	100	36 028

Japanese experiences on extension of coverage

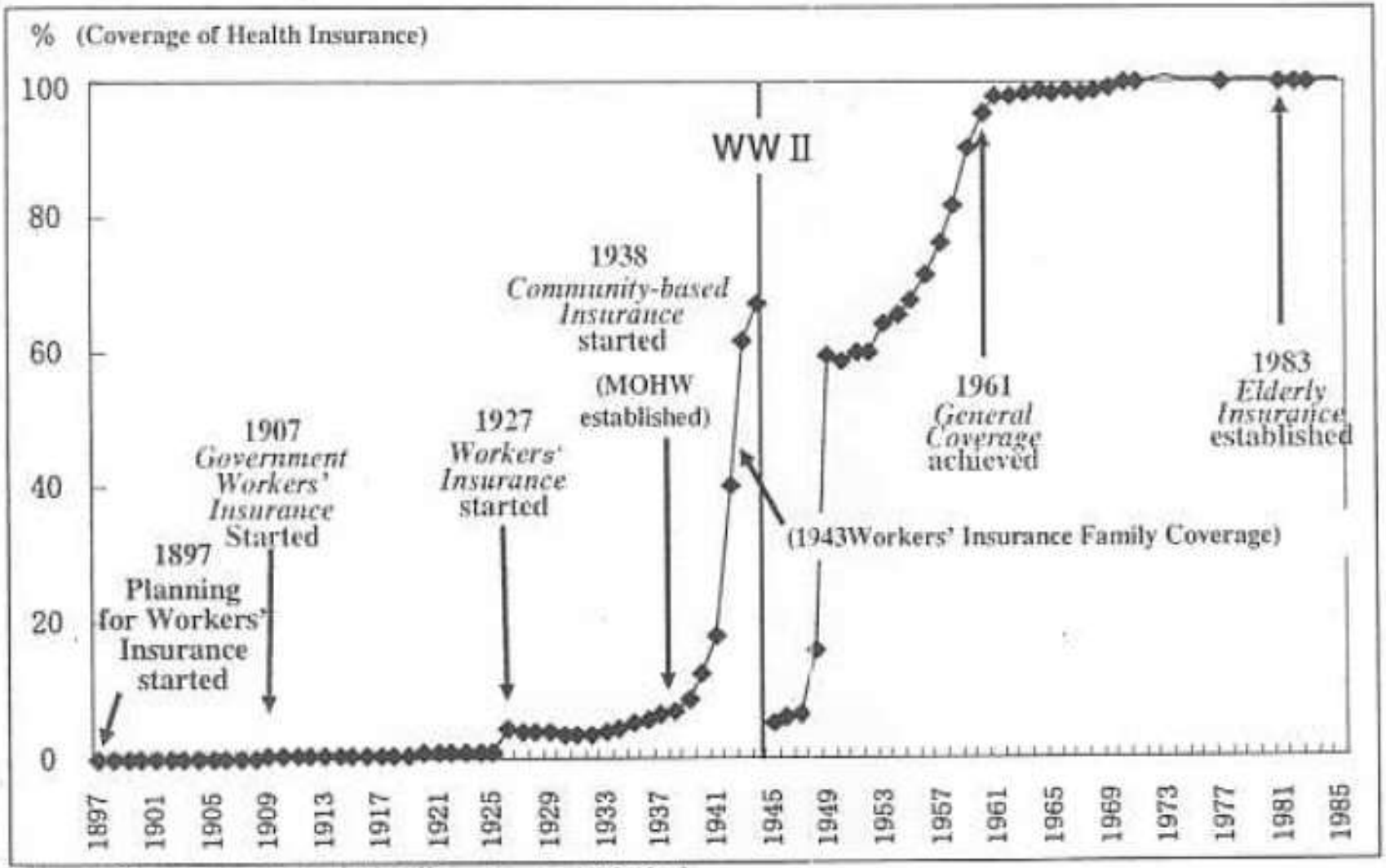
Figure 2-1 Trend in the proportion of primary sector workers



Note: Data on Germany are those of former West Germany

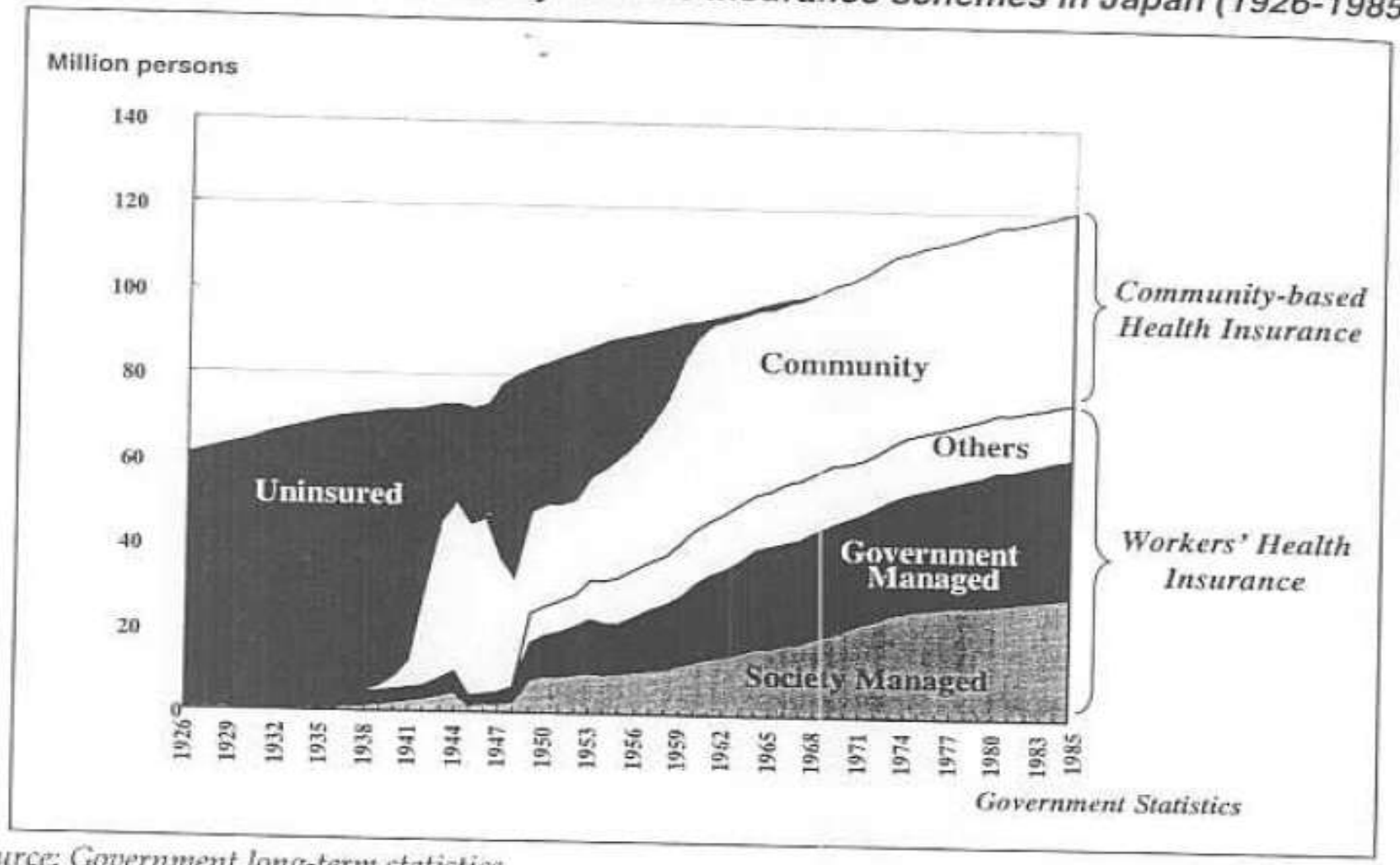
Source: Compiled by the author on the basis of information in ILO annual reports

Figure 3. The growth of health insurance coverage in Japan (1897-1985)



Source: Government statistics (long term statistics)

Figure 4. ***Population covered by various insurance schemes in Japan (1926-1985)***

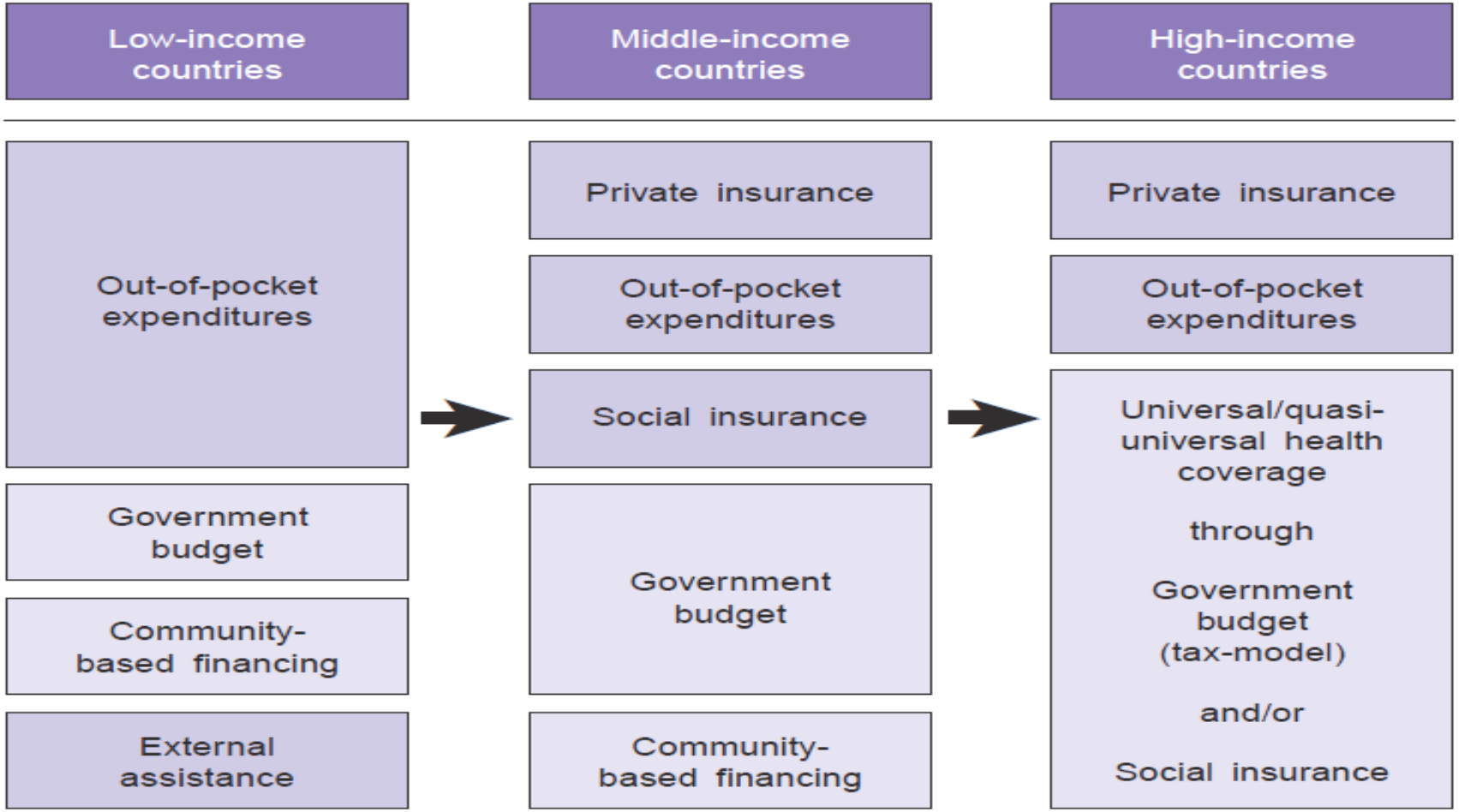


Source: Government long-term statistics

Table 2-3 Participant structure of NHI programs managed by municipalities

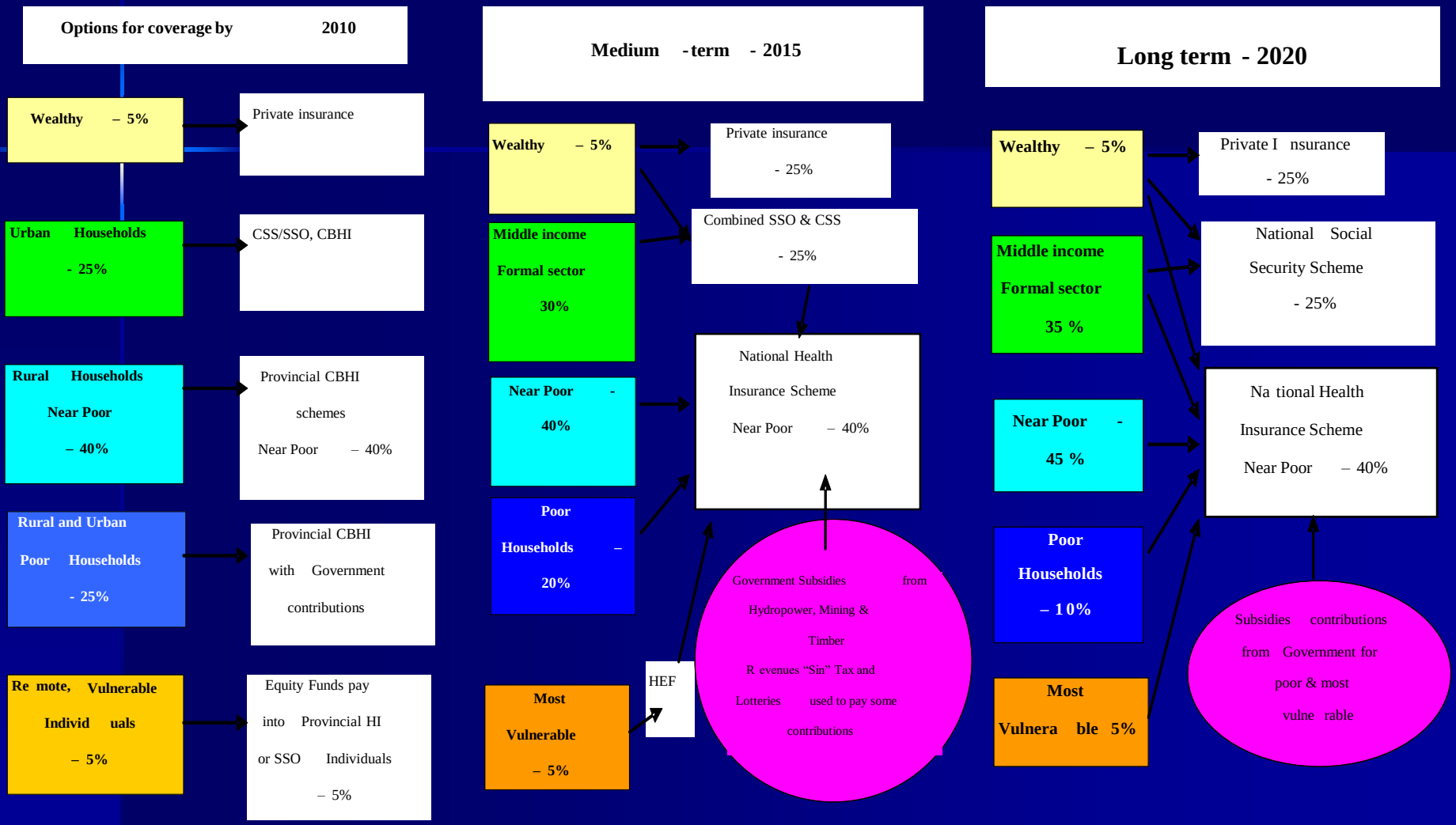
		FY 1961	FY 1992
Proportion of NHI program participants in the total population		47.0%	30.5%
Grouping by participants' (household) occupation	Farmers/Fishers/Foresters	44.7%	9.0%
	Self-employed workers	24.2%	24.7%
	Employed workers	13.9%	23.6%
	Unemployed	9.4%	38.1%
	Others	7.8%	2.3%

Figure 3.5. Evolutionary model of health financing



Source: Adapted from P. Gottret and G. Schieber, *Health Financing Revisited; A Practitioners's Guide* (Washington, D.C., World Bank, 2006).

Extension plan of Lao PDR



5. Concluding remarks

- From the point of view of poverty reduction, better health for all with equity, risk-pooling in a large pool and pre-payment (tax-based or insurance) with considerable redistribution is essential.

- This can be only done through a public system or strict public interventions (e.g. doctors' wage, essential drug lists, standard medical procedures) with considerable public resources (tax, social insurance contributions) allocated to and redistributed for health care financing.

- Economic development supports more public resources to be allocated to health care, and **strong political will is essential** for a larger financing share to be allocated to health care.

- Some middle income countries such as Thailand has achieved universal coverage through plural and countries like the Philippines and Vietnam are on a right track of extending coverage.

- It is important for middle-income countries such as Malaysia and Thailand to broaden the financial channels (e.g. insurance such as Thai SSO) to provide better and quality health care for changing disease profiles e.g. shifting emphasis from infectious diseases to chronic diseases) and to keep health care financing viable amidst the changing environments such as population aging.

- Some low-developed countries like Lao PDR needs to develop combined mechanisms (SSO, CBHIs, Health Equity Funds) to extend the health care coverage.

- Issues of coordination of different schemes will also become more and more important on all aspects, e.g. benefit packages, financing, provider payment mechanism, registration so that it would not provide providers with skewed incentives.

- Participation of stakeholders, especially tripartite partners is essential for better governance of the system.